The College

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I managed to start my term as President of ANZCA on 4 May 2020, just as the COVID-19 pandemic was biting New Zealand and Australia. People were in justified fear of their lives. They were adjusting to restrictions on a scale not experienced since World War II.

Very little was known about the virus. Uncertainty was everywhere. One of the few certainties was that anaesthetists would be on the front line in the management of the most acute cases.

Against that backdrop, all the comforting traditions and rituals of the handover of the governance of ANZCA were impossible. Instead of gathering the new Council in one place to start our new working relationships in person, we were constrained by the limitations of a camera, a microphone and a screen.

Zoom, almost unheard of a year ago, is now the glue that holds organisations together. While it is vastly better than phone conferences, in the words of the song, “There ain’t nothin’ like the real thing.” It is still possible to get from a set of meeting papers at the beginning to a set of minutes at the end, but the missing elements include the unguarded conversations over lunch and dinner, where problem-solving often happens. Also missing is togetherness in time. Five hours of time zones separate the western and eastern boundaries of ANZCA. To take part in the same conversation, Perth has to get up early, and New Zealand has to stay up late.

On 4 May 2020, six of the 13 ANZCA Council members were new. It is a credit to them, and to the returning councillors, that the new relationships are off to a good start.

The hardest project so far has been to find a way to conduct the trainees’ exams. COVID-19 restrictions on gatherings and travel have upended the basic principles on which exams have been conducted until now. For consistency of standards, they were always held in the same place, at the same time, sitting the same papers under the same invigilation and questioned *viva voce* by the same panel of examiners. Suddenly, most of those requirements could not be satisfied. Alternatively, no more exams could be held in 2020. That would clog the pipeline of training for significantly longer than merely during the year of interruption.

The different viewpoints were hard to reconcile. The examiners focused on standards, with a concern that the graduates of 2020 should not be perceived as less thoroughly examined than their predecessors and their successors. They also had a justified anxiety that, while video conferencing has become workaday, a technological failure in a single region could damage the integrity of the whole exam process, to such an extent that recovery would be impossible.

The trainees had equally valid concerns. No-one who has sat a high-stakes exam is ever too old to remember the emotional stresses that go with it, even in the best of times. Candidates pace their preparation in sprints and rests, the sprints requiring intense mental effort. To have the rhythm of their preparation interrupted unpredictably by the caprice of outbreaks of the virus is an exhausting and dispiriting experience for them. That effect is worsened by long periods of uncertainty, while plans to examine in regions were put together, against a backdrop of fresh outbreaks.

With so many variables, there is no perfect answer. Each new problem sparks a search for the best alternative, or the least worst one.

For me and for the ANZCA Councillors and committee members, life is a seemingly endless procession of Zoom meetings. The impact on the running of the College activities has been immense. Despite this, we are in a stable position, and are able to continue support for fellows and trainees.

Strategic plan 2018-2022

1. **Leading** professional identity and Perioperative Medicine;
2. **Growing** lifelong education, training and professional support;
3. **Driving** research and quality improvement; and
4. **Supporting** the workforce and wellbeing.

I expect that my presidency will be dominated by COVID. However, there are 2 (of 4) important things that I flagged at the start, and would still like to achieve if possible.

- Advance Perioperative Medicine
- Te Reo Māori name for the College

Perioperative Medicine – (Strategic plan item 1)

I am still hopeful that I will be able to advance the development of perioperative medicine and deliver the diploma of clinical perioperative medicine, or at least be well on the way towards it by 2022.

The COVID-19 pandemic has suddenly raised public awareness of what anaesthetists do. Against the backdrop of a disease that has killed more than 530,000 people worldwide, our professional expertise has never been so visible, appreciated and sought after. Now is the time to establish ourselves as more than just "intubator experts".

Perioperative Medicine Clinical Diploma

ANZCA has committed significant financial and other resources to this project. Following the positive results from surveys of ANZCA (previously reported), the College of Intensive Care Medicine (CICM) and the Royal Australasian College of Physicians (RACP) (see below), the expert education consultancy group Curio was chosen to review the perioperative medicine "market", and test the interest in enrolling for a diploma.

The findings are:

- There is demand for a formal perioperative medicine qualification.
- The qualification does not need to be conducted in conjunction with a university, because it calls for practical learning experience.
- Potential trainees for the diploma are most likely to be at one to three years post-fellowship.
- The preference is for a course that can be completed within 12 months, or within a flexible, longer timeframe.
- The qualification would probably be broken down into modules or units.
- Units could be completed without doing the whole course.
- The course would be multidisciplinary and inter-professional, with various specialists.
- Prior learning and prior experience of those currently working in perioperative medicine would be recognised. Those individuals could act as supervisors of training.
- One of the key findings was the need to incorporate nonclinical components into the perioperative medicine course such as communication, leadership and collaboration skills.

RACP survey- key findings:

- The group recognised that more experienced geriatricians were less interested in a perioperative medicine qualification, as they believed that they were already practicing perioperative medicine.
- Less experienced geriatricians, including advanced trainees, showed interest and recognised the qualification's benefit.
- Members considered that there was enough support within the geriatric community to develop the qualification.
- The College of Physicians is to work with ANZCA on education and qualification coordination, and logistics.

CICM survey- key findings:

- Intensivists believe they already participate substantially in Perioperative Medicine, and they want to increase participation, as part of multidisciplinary teams.
- A qualification would be attractive for trainees, and would not require much additional training for specialists in higher level ICUs.
- There is ambivalence about the benefit of ICU/HDU admission for patients that are less certain to benefit - i.e., those who do not require invasive ICU support.
- Only 5% agreed that their anaesthetic, physician and surgical colleagues had sufficient expertise to decide on the need for ICU/HDU admission for high risk elective surgical patients.
- If decision-making regarding admission were moved from intensivists, it would potentially create an under, or over, utilisation of scarce ICU/HDU resources and, in turn, could negatively influence patient outcomes and create inefficiencies in ICU utilisation.

Perioperative Medicine Collaborations

Several other initiatives are underway, for example, collaboration with the UK College Centre for Perioperative Care (the Monty Mythen/Mike Grocott group), who have been very generous with their material and time: see https://cpoc.org.uk/

Monty Mythen and Mike Grocott (along with me and members of the Perioperative Steering Committee of ANZCA) attended the "hidden pandemic summit" organised by Prof Guy Ludbroke in Adelaide, facilitated by Norman Swan, and focused on postoperative complications. 88 attended, with representatives from clinicians, administrators, funders public and private, consumer researchers and quality and safety people. The goal was to produce recommendations for the prevention of post-operative complications.

The key principles are -

1. All planning must be based around the patient - their family, their expectations and needs;
2. Risk assessment should be formally determined when surgery is considered;
3. System thinking for perioperative care should apply for all surgery and procedures;
4. The pathway for managing surgical complications starts with primary care;
5. The business case for quality should accompany all activities, initiatives and improvements in the system;
6. Evidence-based approaches should be used within all elements of the system; and
7. Appropriate performance measures should be in place, to guide quality;

There are 34 recommendations in total. All are consumer centric, evidence based, simple to follow, locally adaptable, and applicable to public and private systems. The report is available on their website. https://www.thehiddenpandemic.com/

ANZCA and Māori Health (Strategic plan item 4)

Before 2010, ANZCA had no Indigenous Health Committee (IHC). The College was not involved in mentoring. Data were not collected on Aboriginal, Torres Strait Islands or Māori fellows or trainees. The College had one Indigenous anaesthetist in the whole of Australia.

In early 2018, we launched our Indigenous Health Strategy 2018-2022 and associated background paper, as part of ANZCA's overall strategic plan.

This year, there are a number of exciting developments for Māori and indigenous health in the College:

1. Māori Anaesthetists Network Aotearoa (MANA)

- ANZCA has 45 Māori anaesthetists, with a growing number of trainees every year. ANZCA is committed to growing this number and supporting trainees and Fellows.
- The MANA group convened its first formal network meeting in early July. It will focus initially on connecting with Māori anaesthetists, guiding the College on Māori health policies, protocol and perspectives, and connecting and mentoring Māori trainees.
- MANA members will support the ANZCA efforts at Te Ohu Rata o Aotearoa (the Māori Doctors' Association) Te Ora Annual Scientific Meeting in November 2020, and plan to have a social outing to introduce participants to each other.

2. Te Reo Māori name for the College

To have a Te Reo Māori name for the college is a long-held ambition of mine. It is essential to making Māori fellows and trainees feel welcome and at home in the College – both at the physical premises in St Kilda Rd, and within the fellowship. Acknowledgement of the rich contribution Tangata Whenua bring to the College is an essential part of the journey to equity.

- ANZCA's New Zealand office has engaged Te Reo Māori expert Stephanie Tibble to provide options for a Te Reo Māori name for use in parallel with the College's name in English.
- Three options have been considered by MANA. A preferred option will be put to the ANZCA New Zealand National Committee (NZNC) in November 2020.

3. Indigenous Health Learning Outcomes Project Group

- This group has been convened via the Education Development Executive Committee (EDEC), to improve indigenous learning outcomes in the current curriculum, ready for assessment and accreditation with the Australian Medical Council by March 2023.
- This project group will consider our offerings for education in cultural safety, cultural competence, health equity, and indigenous health principles and practices for both Māori, Aboriginal and Torres Strait Islands people.

4. Growing the profile of indigenous health and Māori and Aboriginal and Torres Strait Islander Fellows at ANZCA.

- In November 2021, the NZNC is hosting a Leadership Hui in Waitangi, with a focus on leadership in the New Zealand context.
- A Reconciliation Action Plan will be progressed at ANZAC in 2021. This this will build on the work of the Indigenous Health Strategy 2018-2022.
- Māori health will be similarly supported with aligned goals and practices.
- In 2021 (if travel is possible) the ANZCA Council will be welcomed to Aotearoa New Zealand with a pōwhiri/welcome at Te Papa (our National Museum), followed by a seminar on Māori health issues.

- In May 2021, the Geoffrey Kaye Museum of Anaesthetic History will produce an exhibition focusing on Māori, Aboriginal and Torres Strait Islander health, to coincide with the Melbourne 2021 ANZCA Annual Scientific Meeting (ASM).

Overview of ANZCA

ANZCA house (Ulimoroa) is located at 630 St Kilda Road which is the traditional land of the Boon Wurrung people of the Kulin nation.

We have about 7,000 fellows and 2,000 trainees. In New Zealand, there are 820 fellows and 220 trainees. Our gender split for trainees is approximately 50:50 and for specialists about 64:46 M:F.

There are 8 regional offices including New Zealand.

Overall, there are about 130 FTE including the Directors of Professional Affairs.

We have over 50 committees and subcommittees that carry out the business of the College. They are all volunteers, supported by the staff.

The College could not be the well-respected, learned institution it is if it were not for the outstanding work and dedication of its Fellows. I thank you for your commitment.